JOHN ENGLER
GOVERNOR

THOMAS D. WATKINS, JR
SUPERINTENDENT OF
PUBLIC INSTRUCTION

July 17, 2002

MEMORANDUM

TO: Full-Day Services Grant for Michigan School Readiness and Head Start Programs
           Contacts

FROM: Judy Levine, Consultant
           Connie Robinson, Consultant
           Office of School Excellence/Early Childhood and Parenting Programs

SUBJECT: 2000-2001 Narrative Summary Report and Financial Reports

Please find the following forms necessary for end-of-year reporting for your 2000-2001 Full-Day
Services Grant for Michigan School Readiness and Head Start Programs. Two reports are
included:

- Narrative Summary Report, **due October 31, 2002**.

- Actual Final Expenditures Report, including summary and detail, for the 2000-2001 Full-Day
  Services Grant for Michigan School Readiness and Head Start Programs allocation, **due
  October 31, 2002.**

**Please plan to mail this report as access to our building has restricted the ability to hand
deliver reports.**

If you have any questions about the Full-Day Services Grant for Michigan School Readiness and
Head Start Programs, please call Connie Robinson or Judy Levine at (517) 373-8483.

Enclosures

AUTHORITY: Section 32d(3) of the State School Aid Act COMPLETION: Required for participating programs .	Direct questions regarding this form to Connie Robinson or Judy Levine, Early Childhood & Parenting Programs, at (517) 373-8483.

MICHIGAN DEPARTMENT OF EDUCATION
OFFICE OF SCHOOL EXCELLENCE
EARLY CHILDHOOD & PARENTING PROGRAMS
P.O. Box 30008
Lansing, MI 48909

Full-Day Services for Michigan School Readiness and Head Start Programs
Narrative Summary (2000-2001)

This document is designed to serve as the year-end report on the state-funded Full-Day Services for Michigan School Readiness and Head Start Programs grants. It includes information on the components required by the Michigan legislature and criteria established by the State Board of Education.

Submit **an original and 1 copy** of this report by **October 31, 2002** to:

Regular Mail
Michigan Department of Education
Office of School Excellence
Early Childhood & Parenting Programs
P.O. Box 30008
Lansing, MI 48909

Overnight/Federal Express
Michigan Department of Education
Office of School Excellence
Early Childhood & Parenting Programs
608 W. Allegan, 4th Floor, Pillar H17
Lansing, MI 48909

Name of District/PSA/Consortium Fiscal Agent:	Subcontract Agency (if any):	
District/PSA/Fiscal Agent Code:	Address:	
Address:		
Contact Person:	Contact Person:	
Phone: ( ) Fax: ( )	Phone: ( )	Fax: ( )
E-Mail Address:	E-Mail Address:	

Signature of Person Completing Report _____   Date _____

Title of Person Completing Report _____

Number of Full-Day Spaces for Michigan School Readiness Program Children	
Planned	Actual

Number of Full-Day Spaces for Head Start Program Children	
Planned	Actual

Length of Services to Children and Families		
Actual Starting Date (mm/dd/yy) of Children's Program	Actual Ending Date (mm/dd/yy) of Children's Program	Total Number of Weeks of Children's Program

I.   Student Information

A.   Number of eligible children served:

_____ 1. ◈ Total number of different children actually enrolled and served during the program year (include dropped and withdrawn children).

_____ 2. Largest number of children's spaces filled at any time during the program year. (Choose the date on which the largest number of children were <u>enrolled</u>, not present. You may choose different dates for each site, if you operate multiple sites with separate waiting lists.)

B.   Description of all children who participated in the Full-Day Services for Michigan School Readiness and Head Start Program (<u>based on the number of children reported in A1 above</u>):

American Indian or Alaskan Native		Asian or Pacific Islander		Black, Not of Hispanic Origin		Hispanic		White, Not of Hispanic Origin		Multiracial		◈Grand Total # of Children	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female

Numbers with this symbol ◈ must match.
THE GRAND TOTAL MUST EQUAL THE SUM OF THE CATEGORIES.

C.   Waiting List

_____   1.   Did the Consortium/School District/PSA have a waiting list of eligible children for Full-Day Services? (yes or no)

_____   2.   If yes, how many eligible children were on the waiting list and unserved at the end of the year?

II.   Program Personnel

Number of teachers, associate teachers, and aides participating in the Full-Day Services Program part of the day by race and gender.

	American Indian or Alaskan Native		Asian or Pacific Islander		Black, Not of Hispanic Origin		Hispanic		White, Not of Hispanic Origin		Multiracial		*Grand Total # of Staff	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total Each Male	Female
Teachers														
Associate Teachers and Aides														

*THE GRAND TOTAL MUST EQUAL THE SUM OF THE CATEGORIES.**

III.   **Quality Improvement**

Using the *Program Quality Assessment* (PQA) tool, briefly describe:

A. How program objectives requiring improvement (where scores were moderate 3-4
to low 1-3) were addressed?

B. What professional development opportunities were attended which support the
implementation of the above program goals and objectives?

IV.   **Program and Participant Evaluation**

    A. Briefly complete the following chart to provide an evaluation of the implementation of the program plan. **Report on the completion, revision, or noncompletion of objectives and activities <u>you previously submitted on the original application</u>.** Use attachments as necessary. Note: These are program objectives chosen from items on the PQA tool where scores were moderate 3-4 to low 1-3.

PROJECT GOALS	CRITICAL OBJECTIVES	ACTIVITIES/ TASKS/STAFF	DATE COMPLETED	OUTCOME EVALUATION WITH MEASUREMENTS

B.   Additional Professional Development:

	Number of Teachers	Number of Associate Teachers	Number of Administrators	Number of Other Personnel	Total Number of Staff
Michigan Department of Education, Early Childhood & Parenting Programs MSRP Fall Kick-Off – various locations (September 2001)					
Michigan Department of Education, Early Childhood & Parenting Programs Full-Day Evaluation TA (September 2002 at Kick-Off locations)					
MiAEYC Early Childhood Seminars (various communities, Fall 2001)					
Full Day Services for MSRP and Head Start Sustainability TA (December 6, 2001)					
Michigan Early Childhood Collaborative Conference (Dearborn, January 2002)					
MiAEYC Annual Conference (Grand Rapids, March 2002)					
Regional or Other Forms of Training Conferences. Please identify. Use additional pages as needed.					
Other: Please describe. (Head Start training and/or conferences, 4C training, college courses, etc.)					

C. What program assessment instruments other than the required *Program Quality Assessment* have you used? (Please check all those that apply.)

     ECERS (*Early Childhood Environment Rating Scale*)

     NAEYC Accreditation Self-Study
     Is the program currently accredited?   yes   no

     Others (please list)
     _____

D. Evaluation Training

    1. Please indicate how many, if any, of your Full-Day staff attended the workshops offered by the High/Scope Educational Research Foundation.

	Number of Teachers	Number of Associate Teachers	Number of Adminis-trators	Number of Other Personnel	Total Number of Staff
C.O.R.					
Computer C.O.R.					
P.Q.A.					

    2. Please indicate the effects, if any, the High/Scope trainings have had on the program.

       _____ Increased general knowledge of classroom quality and child development for individual staff.
       _____ Stimulated discussion among staff around issues of planning and/or assessment.
       _____ Enhanced the process of program evaluation.
       _____ Increased the number of staff involved in assessment and evaluation practice and planning.

V.   **If your full-day model:**

    A. used the wrap-out model design, please articulate how and when payments were made to the wrap-out provider(s):

    B. included Head Start services to children, were the full-day funds used as a match for Head Start? If yes, what portion was used as match?

VI.   **Expenditure Report**

Report on the total expenditures for the full-day portion of services on both the Final Expenditures Summary and Detail. The totals should reflect the grant funded amount and the 50 percent match amount. (For example, if the grant was for $100,000, the total expenditure would be at least $150,000.) **Failure to report match may result in the recapture of funds to reflect the actual contributions to the program**. A second final expenditure detail attachment should provide the actual source of matching funds.

GRANT FINAL EXPENDITURES FORM

Instructions: The Final Expenditure Summary and the Final Expenditure Detail must be prepared by or with the cooperation of the Business Office using the Michigan School Accounting Manual (Bulletin 1022).

1. FINAL EXPENDITURE SUMMARY--

LEGAL NAME OF APPLICANT					
RECIPIENT/DISTRICT CODE (Maximum of 10 characters)	**GRANT NUMBER** (6 characters)	**PROJECT NUMBER** (Maximum of 12 characters)	**PROJECT TYPE** : Regular **9** Carryover	**ENDING DATE** **0 9 3 0 0 2**	**FY of Approved Activity** **2001**

BUDGET: **OBJECTS:**

FUNCTION CODE	FUNCTION TITLE	SALARIES	BENEFITS	PURCHASED SERVICES	SUPPLIES & MATERIALS	CAPITAL OUTLAY	OTHER EXPENDITURES	TOTAL EXPENDITURES
110	Instruction—Basic Programs							
120	Instruction – Added Needs							
130	Instruction – Adult/Continuing Ed.							
210	Pupil Support Services							
220	Instructional Staff Services							
230	General Administration							
240	School Administration							
250	Business Services							
260	Operation and Maintenance							
270	Pupil Transportation Services							
280	Central Support Services							
290	Other Support Services							
300	Community Services							
400	Outgoing Transfers & Other Transactions							
	CAPITAL OUTLAY							

	TOTAL EXPENDITURES	A
FUNDING **Department of Education Share of Expenditures**		B
Local Share of Expenditures (Block A Minus Block B)		C

2. FINAL EXPENDITURE DETAIL

Explain each line item that appears on the Final Expenditure Summary, using the indicated function code and title, on a plain sheet. *(Provide attachments as needed.)*

DATE	BUSINESS OFFICE REPRESENTATIVE (Type or Print)	SIGNATURE
DATE	PROJECT CONTACT PERSON (Type or Print)	SIGNATURE
DATE	CONNIE ROBINSON OR JUDY LEVINE M.D.E. CONTACT PERSON (Type or Print)	SIGNATURE